

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH  
BUREAU OF FAMILY, MATERNAL AND CHILD HEALTH

VISION TECHNICIAN ASSESSMENT PROGRAM (TAP)  
**PAYMENT VOUCHER WORKSHEET**

**SERVICES COMPLETED:**

Health Department: \_\_\_\_\_ Date: \_\_\_\_\_  
City: \_\_\_\_\_ County: \_\_\_\_\_

**TECHNICIAN INFORMATION:**

Technician(s) observed: \_\_\_\_\_

Site of observation: \_\_\_\_\_ City: \_\_\_\_\_

Address: \_\_\_\_\_ Phone contact: \_\_\_\_\_

**TAP EVALUATOR:**

Name: \_\_\_\_\_ Signature: \_\_\_\_\_  
(please type or print)

Social Security #: \_\_\_\_\_ or Federal ID #: \_\_\_\_\_

\_\_\_\_\_  
(use only one number; SSN for payment to individual; FID for payment to business or employer)

Send Payment TO: \_\_\_\_\_

**TRAVEL DETAIL:** Attach receipts. Reimbursement cannot exceed current State Standardized Travel Regulations (see back).

Departure Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM PM Return Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM PM

Meals: Breakfast: \_\_\_\_\_ Lunch: \_\_\_\_\_ Dinner: \_\_\_\_\_

Lodging: \_\_\_\_\_ Miles to Site: \_\_\_\_\_ Total miles: \_\_\_\_\_

**MDCH USE ONLY**

Miles roundtrip: \_\_\_\_\_ X \_\_\_\_\_ = Mileage \$ \_\_\_\_\_

Lodging: \_\_\_\_\_ Meals: \_\_\_\_\_

TAP Professional Fee: \_\_\_\_\_ Total voucher amount: \$ \_\_\_\_\_

Approved: _____	_____
(Hearing/Vision Program Consultant)	Children's Health Unit Manager
Date: _____	Date: _____